USAR OR ARNG APPLICATION FOR CLINICAL PRIVILEGES TO PERFORM ACTIVE OR INACTIVE DUTY TRAINING

For use of this form, see AR 40-68; the proponent agency is OTSG

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Authority: Title, 5, United States Code (USC), Sections 301; Title 44, USC, Section 3101; and Title 10, USC, Section 1071.

Principal Purpose: To define the extent and limits of the practitioner's clinical privileges as a function of his or her training experience.

Routine Uses: Determine and asses capability of practitioner's clinical practice. A copy of this form will be retained in your credentials file. Information may be provided to certain civilian hopitals, the Federation of State Medical Boards of the U.S., State Licensure authorities, and other appropriate professional regulating bodies.

Disclosure: Disclosure of information requested is voluntary. However, failure to provide the required information may result in the limitation or termination of your clinical privileges.

SECTION A - IDENTIFICATION

1. NAME *(Last, first, middle)*	2. SOCIAL SECURITY NO. *(SSN)*	3. DOB	4. GRADE

5. CORPS	6. UNIT IDENTIFICATION	7. SPECIALTY BY TRAINING

SECTION B - BASIC INFORMATION

8. LICENSURE/CERT.		9. DATE(S)	10. EXPIRATION DATE(S)
a. State Licensure *(If any)*			
b. DEA Number *(If any)*			
c. CPR Certificate			
d. ACLS Certificate			
e. BCLS Certificate			

11. BOARD ELIGIBLE FROM *(Date)*	12a. BOARD EXAM TAKEN *(Date)*	12b. CHECK ☐ Total ☐ Partial	14. MEMBERSHIP IN SPECIALTY SOCIETIES *(Specify)*

13. BOARD CERTIFIED? *(If yes, give name of Board(s).*
☐ Yes ☐ No

15. Current Hospital Privileges

a. NAME OF HOSPITAL	b. LOCATION	c. TYPE OF APPOINTMENT

16. Interval information *(If Yes to any of the following questions, give full details on a seperate sheet of paper.)*

In the last year, have you:	YES	NO
a. Have you had any final unfavorable liability judgments?		
b. If yes, any liability payments above $100,000?		
c. Have you been the subject of **any** disciplinary action by **any** local or state medical society or **any** licensing agency?		
d. Have you had you clinical privileges limited, revooked, or otherwise modified at **any** institution?		
e. Resigned from the staff of any hospital?		
f. Been treated for drug or alcohol abuse?		
g. Not maintained you state's continuing medical education requirements?		

	YES	NO
h. Would you feel comfortable and competent to perform your AD Training as a General Medical Officer in the **Outpatient Clinic?**		
i. Would you feel comfortable and competent to perform your AD Training as a General Medical Officer in the **Emergency Care area?**		
j. Do you certify that you are mentally and physically able to practice medicine?		

17. COMMENTS

The information contained herein is true to the best of my knowledge and belief.	18a. SIGNATURE OF APPLICANT	18b. DATE

SECTION C - ARNG OR USAR UNIT COMMANDER'S RECOMMENDATIONS

That clinical privileges be granted to the named applicant for Active or Inactive duty.

1. NAME

2. PERIOD

FROM

TO

3. MEDICAL TREATMENT FACILITY OR DENTAC

4. BY EDUCATION AND TRAINING, THIS PRACTITIONER IS QUALIFIED IN THE FOLLOWING

SPECIALTIES	UN-KNOWN	YES	NO
a. Primary			
b. Secondary			
6. This practitioner has the capability of performing the medical duties required of a General Medical Officer or General Dentist.			
7. All documents of education, training, licensure/certification/registration and ECFMG (if applicable) have been verified with a primary source.			

5. PRACTITIONER'S DEMONSTRATED CLINICAL COMPETENCY REMARKS

8a. NAME OF VERIFYING INDIVIDUAL	8b. GRADE	8e. SIGNATURE
8c. TITLE	8d. DATE	
9a. NAME OF UNIT COMMANDER	9b. GRADE	9e. SIGNATURE
9c. TITLE	9d. DATE	

SECTION D - RECOMMENDATIONS OF SITE CREDENTIALS COMMITTEE

10. REMARKS

11. RECOMENDED STATUS

☐ Conditional ☐ Full

12. CLINICAL PRIVILEGES RECOMMENDED

☐ As Requested ☐ Other *(Specify in Item 12.)*

13a. NAME OF CREDENTIALS COMMITTEE CHAIR	13b. GRADE
13c. SIGNATURE	13d. DATE

SECTION E - APPROVING AUTHORITY

14a. NAME OF MTF OR DENTAC COMMANDER	14b. SIGNATURE	14c. DATE